CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT
[Prior to 7/1/83, Social Services[770] Ch 80]

441—80.1(249A) The fiscal agent function in medical assistance. Rescinded IAB 5/25/05, effective 7/1/05.

441—80.2(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to the Iowa Medicaid enterprise on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after the end of the calendar month in which the services are provided. Following audit of the claim, Iowa Medicaid will make payment to the provider of care.

80.2(1) Electronic submission. Providers are required to submit claims electronically whenever possible.

a. When filing electronic claims, pharmacies shall use the format prescribed by the National Council for Prescription Drug Programs.

b. Claims submitted electronically shall be filed on the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837 transaction, Health Care Claim.

(1) Providers listed as filing claims on Form CMS-1500 or on the Claim for Targeted Medical Care shall file claims on the professional version of the 837 Health Care Claim.

(2) Providers listed as filing claims on Form CMS-1450 or UB04 shall file the institutional version of the 837 Health Care Claim.

(3) Dentists shall file the dental version of the 837 Health Care Claim.

(4) Pharmacists providing drugs and injections shall use the format prescribed by the National Council for Prescription Drug Programs.

c. If a claim submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use the Iowa Medicaid portal access (IMPA) system to submit supporting documents when billing Medicaid fee for service claims; and

(2) Reference the attachment control number submitted on the ASC X12N 837 electronic transaction.

80.2(2) Claim forms. Claims for payment for services provided recipients shall be submitted on Form CMS-1500, Health Insurance Claim Form, except as noted below.

a. The following providers shall submit claims on Form UB-04, CMS-1450:

(1) Home health agencies providing services other than home- and community-based services.

(2) Hospitals providing inpatient care or outpatient services, including inpatient psychiatric hospitals.

(3) Psychiatric medical institutions for children.

(4) Rehabilitation agencies.

(5) Hospice providers.

(6) Medicare-certified nursing facilities.

(7) Nursing facilities for the mentally ill.

(8) Special population nursing facilities as defined in 441—Chapter 81.

(9) Out-of-state nursing facilities.

(10) Health insurance premium payment (HIPP) providers.

b. All other nursing facilities and intermediate care facilities for persons with an intellectual disability shall file claims using an electronic version of Form UB-04 CMS-1450.

c. Pharmacies shall submit claims on the Universal Pharmacy Claim Form when filing paper claims.

d. Dentists shall submit claims on the dental claim form approved by the American Dental Association.

e. Providers of home- and community-based waiver services, including home health agencies, shall submit claims on Form 470-2486. In the event of the death of the member, the case manager or service worker shall sign and date the claim form if the services were delivered.

f. Case management providers billing services provided pursuant to 441—Chapter 90 to fee-for-service members shall submit claims using a HIPAA-compliant electronic claim.

g. For fee-for-service members, providers billing claims for Medicare beneficiaries that do not cross over electronically to Iowa Medicaid must submit the following electronically, in accordance with the All Providers, IV. Billing Iowa Medicaid manual, located at dhs.iowa.gov/sites/default/files/All-IV.pdf:

(1) Form UB-04.

(2) Form CMS-1500. The Explanation of Medicare Benefits (EOMB) is only required when requested by Iowa Medicaid.

h. For managed care members, providers billing claims for Medicare beneficiaries that do not cross over electronically must submit the following electronically:

(1) Form UB-04 and the Explanation of Medicare Benefits (EOMB); and

(2) Form CMS-1500 and the Explanation of Medicare Benefits (EOMB).

i. Health insurance premium payment (HIPP) providers shall submit Form 470-5475 along with an explanation of benefits (EOB).

80.2(3) Providers shall purchase their supplies of forms CMS-1450 and CMS-1500 for use in billing.
[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9724B**, IAB 9/7/11, effective 9/1/11; **ARC 9889B**, IAB 11/30/11, effective 1/4/12; **ARC 2165C**, IAB 9/30/15, effective 12/1/15; **ARC 3159C**, IAB 7/5/17, effective 7/1/17; **ARC 3296C**, IAB 8/30/17, effective 10/4/17; **ARC 3494C**, IAB 12/6/17, effective 1/10/18; **ARC 4751C**, IAB 11/6/19, effective 12/11/19; **ARC 5248C**, IAB 11/4/20, effective 1/1/21; **ARC 6851C**, IAB 2/8/23, effective 4/1/23]

441—80.3(249A) Payment from other sources. This rule applies to claims for the department, managed care organizations, and the Public Health Associate Program (PHAP).

80.3(1) *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source shall be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.3(2) *Third-party liability.*

a. When a third-party liability for medical expenses exists, this resource shall be utilized for payment of a claim before the Medicaid program makes payment unless:

(1) The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This "pay and chase" provision applies to claims for:

1. Preventive pediatric services, and
2. All services provided to a person for whom there is court-ordered medical support.

(2) Otherwise authorized by the department.

b. All claims must be clean claims. A clean claim is defined as a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim.

80.3(3) *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. No later than 60 days after receiving any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service, respond to such inquiry, pursuant to 42 U.S.C. Section 1396a(25)(I)(iii), effective March 13, 2022.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point of sale that is the basis of the claim, or, in the case of a responsible third party (other than the original Medicare fee-for-service program under Parts A and B of 42 U.S.C. Chapter 7, Subchapter XVIII, a Medicare Advantage plan offered by a Medicare Advantage organization under Part C of 42 U.S.C. Chapter 7, Subchapter XVIII, a reasonable cost of reimbursement plan under 42 U.S.C. Section 1395mm,

a health care prepayment plan under 42 U.S.C. Section 1395l, or a prescription drug plan (PDP) offered by a PDP sponsor under Part D of 42 U.S.C. Chapter 7, Subchapter XVIII), a failure to obtain a prior authorization for the item or service for which the claim is being submitted, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

d. Agree not to deny any claim submitted by the state solely because of lack of prior authorization.

[**ARC 7547B**, IAB 2/11/09, effective 3/18/09; **ARC 6022C**, IAB 11/3/21, effective 1/1/22; **ARC 6851C**, IAB 2/8/23, effective 4/1/23]

441—80.4(249A) Time limit for submission of claims and claim adjustments.

80.4(1) *Submission of claims.* Payment will not be made on any claim when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by Iowa Medicaid exceeds 365 days. The department shall consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

80.4(2) *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by Iowa Medicaid within 365 days from the date the claim was last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

80.4(3) *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

[**ARC 1155C**, IAB 10/30/13, effective 1/1/14; **ARC 6851C**, IAB 2/8/23, effective 4/1/23]

441—80.5(249A) Authorization process.

80.5(1) *Identification cards.* The department shall issue a Medical Assistance Eligibility Card to members for use in securing medical and health services available under the program except as provided in 441—Chapter 76.

a. The department shall issue the Medical Assistance Eligibility Card:

(1) When the member's eligibility is initially determined.

(2) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The Medical Assistance Eligibility Card is valid only for months in which the member has established eligibility, as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.5(2) *Third-party liability.* Rescinded IAB 2/11/09, effective 3/18/09.

[**ARC 7547B**, IAB 2/11/09, effective 3/18/09; **ARC 6851C**, IAB 2/8/23, effective 4/1/23]

441—80.6(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below:

80.6(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with 441—Chapter 75.

80.6(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.6(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

a. Related to the cost of processing the billing.

b. Not related on a percentage or other basis to the amount that is billed or collected.

c. Not dependent upon the collection of the payment.

[**ARC 6851C**, IAB 2/8/23, effective 4/1/23]

441—80.7(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance state plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406), service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

80.7(1) *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. A data use agreement shall prescribe the specific detail elements required, in addition to any privacy protections, in the manner in which information shall be provided to the department of human services, or its designee, and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department or its designee to match covered persons and identify third-party payers for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

80.7(2) *Confidentiality of data.* The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164 as amended to April 11, 2022.

[**ARC 1070C**, IAB 10/2/13, effective 10/1/13; **ARC 6851C**, IAB 2/8/23, effective 4/1/23]

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